STATEMENT OF DEFICIENCIES UND PLAN OF CORRECTION	E & MEDICAID SERVICES  (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	- 3/29//4 PLE CONSTRUCTION	FORM AP DMB NO. 09 (X3) DATE SU
name of provider or supplier	446303	A. WING_		COMPLE
NORRIS HEALTH AND REHAL	BLITATION CENTER		STREET ADDRESS. CITY, STATE, ZIP CODE 3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 27705	02/12/2
	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY HILL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED OFFICIENCY)	N BE COL
Personal privacy included in medical treatment, we communications, par meetings of family and does not require the factor, the resident release of personal arindividual outside the and clinical records do resident is transferred institution; or record resident must keep.	right to personal privity and or her personal and clinical udes accommodations, ritten and telephone sonal care, visits, and id resident groups, but this facility to provide a private nit.  paragraph (e)(3) of this may approve or refuse the nid clinical records to anny facility.  refuse release of personal pes not apply when the to another health care please is required by litw, confidential all information into records, regardless of ethods, except when rensfer to another sw; third party payment it.	F 164		the facts ment of mared ad by the  the  the  rand

Any deficiency statement ending with an asterior,") denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the parismise. (See instructions.) Except for musting homes, the findings stated above are disclosable as days following the date of survey whether or not a pion of correction is provided. For nursing homes, the above findings and pions of correction are disclosable 14 dependently in the date those documents are made available to the facility. If deficiencies are clied, an approved pion of correction is requisite to continued

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STATEME	ERS FOR MEDICAR VI OF DEFICIENCIES OF CORRECTION	DC0547PM13501 HAND HUMAN SERVICES E & MEDICAID SERVICES  (XI) PROVIDENSUPPLER CLA	-,,-	3652125642 >>	8654948043 FOR	MARROO
	OF CORRECTION	DENTIFICATION NUMBER:	(X2) MULT A. BUILD!!	TIPLE CONSTRUCTION NG	(X3)	O. 0938 ( TE SURVE MPLETED
NAME OF	PROVIDER OR SUPPLIER	446303	A. WING.			
	HEALTH AND REHAL	BILITATION CENTER		STREET ADDRESS, CITY, STATI	ELVIA COOR	/12/2014
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F 164	Continued From pag	ge 1	F 184		NOY	
li 8	hallway, revealed LP at the medication can Administration Recorded the president and the president and the president and the MAR of the oart, exposing a formation, and enterded with LPN #2 :57 a.m., in the hallwaying the cart, and the oat been maintained.	on February 10, 2014, at ay, confirmed the resident's R was to be covered before the resident's privacy had		"Preparation and/or execut correction does not constitu- agreement by the provider alleged or conclusions set if deficiencies. The plan of co- and/or executed solely beer provisions of federal and st	ute admission or of the truth of the facts forth in the statement of preceion is prepared	
242 ; 40 IS=D ! M	33.16(b) SELF-DETE AKE CHOICES	RMINATION - RIGHT TO	F 242	F 242		
he ins ab are	r interests, assessmeract with members aide and outside the fout aspects of his or asignificant to the relative REQUIREMENT is	ght to choose activities, care consistent with his or ents, and plans of care; of the community both sollly; and make choices her life in the facility that sident.		1. Corrective action I accomplished for the deficient practice in resident # 67. Resident assessed for transfers assistance needed an interviewed by Sociand unit manager as personal choice prefers	ne alleged regards to lent has been ferring al Services to offered	
Ba and pre	sed on medical raco	rd review, observation,		her care related to witto be out of bed when	han to and	

	C-25 13:49 November Of Mealin ERS FOR MEDICARI	DC0547PM1350	ŧ	3652125 <i>6</i> 42 >>	3043 P 4/13
STATEME	NT OF DEFICIENCIES LOF CORRECTION	AND HUMAN SERVICES  & MEDICAID SERVICES  (X1) PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILON	TIPLE CONSTRUCTION	FORM APPROVED MR NO. 0938-038
NAME		445303	B. WING_		COMPLETED
	PROVIDER ON SUPPLIER HEALTH AND REHAE		1 - Wild	STREBT ADDRESS, CITY, STATE, ZIP CODE	02/12/2014
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F 242	Continued From pag	ge 2	F 242	)!	
	The findings included			2. Oriented residents needing assistance with transferring b	ave
		admitted to the facility on diagnoses including	!	the potential to be affected by alleged deficient practice. Au will be done to determine the	/ the
į.	Chronic Atrial Fibrillar Malnutrition, Diabetes Anxiety, Morbid Obes Decubifi.	ion, rrypertension, 5 Mellitus, Depression Sity, and Healing Stage IV		they will also he reassess and	. am 1
in the standard of the standar	Medical record review Data Set (MDS) dated avealed the resident are resident interview for Market and Interview revealed the selstance from two selstance from two selstance from two rependent with assistance from two the selstance from two anafers.  eview of the Mental anafer	of the Quarterly Minimum December 31, 2013, scored 15 out of 16 on the scored 15 out of 16 on the stall Status exam indicating litively intact. Continued resident required extensive ersons for activities of daily glene, and was totally ance of two persons for was totally ance of two persons for 25, 2013, January 7, 2014, revealed, "wints for to distractand afficant sleways followreally needs to get out tates has esked to get up afficant seem to find the i and defeated"		interviewed for preferences Therefore, staff has offered personal choices of getting out bed as requested. The licensed nurse will be notified when residents refuse to get out of be to assure that preferences are being met.  3. In-service/re-education nursing staff by DON, Unit manger, nursing supervisors for Residen choices being honored to get ou of bed must be met to ensure for continued compliance. The licensed nurse will be notified when a resident refuse to get out of bed to assure that preferences are being met.	ed sts
Fel	idical record review o spitulation orders dai bruary 28, 2014, reve of bed daily as per p	led February 1 through			
Ob:	servation on February 1 February 12, 2014, :	v 11, 2014, at 10:30 H.m., at 10:00 a.m., in the	İ	•	

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CTATELO	ERS FOR MEDICARE	DCD547PM13501 TAND TOWNER SERVICES & MEDICAID SERVICES			2125642 >>	8654948043	P 5/
AND PLAN	NT OF DEFIDIENCIES OF CORRECTION	IMU PROVINCOM MANAGEMENT				Ė	CITAL MISTO
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F 242	Continued From page	- ^		<del>-</del>	met i felët.	107)	!
}	residently some	93	F 24	9 4,	The Unit Manage	re at Director -4	, ———
i	Loons during LOOILL' 16AB	aled the resident was in bed.	, ""	~{	Nursing will revie	as of Director Of	
1.	Observation and total	ndam	ł	1	during ambassado	r andite coolette	' 1
			}	1	services will inter	View toeidanta 2	İ
į	arth borniinco, .m.e	sident required assistance			times a week x 3n	nonths to	1
18	and the use of a lift fo	transfers to get out of the		1	determine if prefer	rences are mes	1
					Social Services wi	Honora are mer	-
ا ا	had not been able to g	et out of the bed as often			data and report par	Herno/trando to	1
je	is desired due to "not	enough staff to get me up."		ĺ	the QAPI committ	ee monthly for	
12	stated. "I am aware of	the extra time and		}	3 months. The QA	PI committee	
				ŀ	will evaluate the et	ffectiveness of	İ
l w	the manny to track (US)	iff. They (staff) tell me they		i	the above plan, and	i will add	
:	o wot (116)	uever do."		!	additional interven	tions based on	
מו	iterview with the Direc	itor of Nursing (DON), in			outcomes identified	d to ensure	
				i	continued complian	nce	1
a.	m., confirmed no kno	Wiedge the resident had	j		<b>p</b> ******	100,	03/14/
		tout of bed when	- !	"Pren	athlan and/	_	1
rex	quested.	at at aga tot lott		correc	raration and/or execution of the document of t	of this plan of	1,
'		į	1	agreet	ment by the provider of the	iamission of	1
F 268 148	9 14(6)(5) 1 (0) 100	İ	}	Rliego	d or conclusions set forth	in the statement of	1
SSED MA	83.15(h)(2) HOUSEKEEPING & IAINTENANCE SERVICES	EPING &	F 253	and/or	encies. The plan of correct	tion is prepared	
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The	e facility must provide	hot maleau - two			and and 1	uw.	
1 1316	INVESTIGATION NATIONAL PROPERTY OF THE PROPERT	300000mm.i	]				•
san	iltary, orderly, and co	Mortobie interior	!	F 253	,		
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		Ì			Corrective action ha		
) [[]]	S KEQUIREMENT IS	not met as evidenced		8	ecomplished for the	alleged	
· oy.		,	i	d.	leficient practice in r	egards to the	
· pas ! falla	ad to keep the better	id interview, the facility	1		trooms identified ha		
1	, pegmaña. La ro keeb tue uslimañ	o free of odors for wo of			leep cleaned to inclu nattresses	ae ;	
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The	findings included:						
Obs	ervation during the su	May from Cohouse	}	•		ļ	

2014-02-25 13:49 DETANTIMENT OF HEALTH AND HUMAN SERVICES DC0547PM1350# 8652125642 >> CENTERS FOR MEDICARE & MEDICAID SERVICES 8654948043 P 6/13 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (XX) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO, 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING NAME OF PROVIDER OR SUPPLIER 445303 B. WING STREET ADDRESS, OITY, STATE, ZIP CODE 02/12/2014 Norris Health and Rehabilitation Center 3392 Andersonville Highway ANDERSONVILLE, TN 37705 SUMMARY STATEMENT OF DEFICIENCIES
(BACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID PREFIX TAG TAG DEFICIENCY F 253 | Continued From page 4 10-12, 2014; of the one hundred hallway, Residents residing in the facility F 253 | 2. revealed unpleasant, foul odors. Continued on 100 and 300 hallways have the observation revealed the unpleasant, foul odors potential to be affected by the were in two rooms on the 100 hall. alleged deficient practice, In-service/re-education to staff by Interview with the Director of Nursing on February administrator, housekeeping 1 12, 2014, at 8:65 a.m., in one of the rooms on the supervisor and DON, unit 100 half, confirmed was aware of the rooms manager, nursing supervisor on having unpleasant, foul odors due to the famility reporting any odors immediately not able to regularly clean the air mattress used to Housekeeping supervisor. The for the residents in the room. Continued interview mattress liners will be placed on revealed the resident in one room (private room) was aware of the odor and had asked the facility routine cleaning to coincide with to hang cloves in the room to help with the odors. showers and as needed. Mattress Liners will be replaced as needed. Observation during the survey from February 10-12, 2014, revealed the three hundred heliway Rounds will be done 3 times had a foul odor, and appeared to be from one weekly x 3 months by department room. Continued observation revealed the cdor heads assigned by administrator was a strong urine smell, to verify current plan and to identify any ongoing concerns Interview with Licensed Practical Nurse #1 on The results of these will review in February 12, 2014, at 9:40 am, in the three morning meeting Monday though hundred hallway, confirmed the small was urine Friday and data obtained will be smell coming from the room. analyze and report patterns/trends to the QAPI committee monthly F 279 483,20(d), 483,20(k)(1) DEVELOP for 3 months. The QAPI SSED COMPREHENSIVE CARE PLANS F 279 committee will evaluate the effectiveness of the above plan, A facility must use the results of the assessment and will add additional to develop, review and revise the resident's interventions based on outcomes comprehensive plan of care. identified to ensure continued compliance. The facility must develop a comprehensive care plan for each resident that includes measurable 03/14/14 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial

2014-02-25 13:49 DEPARTMENT OF HEALTH AND HUMAN SERVICES DC0547PM13501 CENTERS FOR MEDICARE & MEDICAID SERVICES 8652125642 >> 8654948043 P 7/13 STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION (X1) PROVIDENSUPPLIERICILIA EDENTIFICATION NUMBER: FORM APPROVED (X2) MULTIPLE CONSTRUCTION MB NO. 0938-0391 V BOILDING" (X2) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 446303 norris health and rehabilitation center STREET ADDRESS, CITY, STATE, ZIP CODE 02/12/2014 3392 ANDERSONVILLE HIGHWAY SUMMARY STATEMENT OF DEPICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ANDERSONVILLE, TN 37705 (X4) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG COMPLETION DATE DEFIDIENCY) F 279 Continued From page 5 "Preparation and/or execution of this plan of needs that are identified in the comprehensive correction does not constitute admission or assessment. agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of The care plan must describe the services that are deficiencies. The plan of correction is prepared to be furnished to attain or maintain the resident's and/or executed solely because it is required by the highest practicable physical, mental, and provisions of federal and state law." psychosocial well-being as required under F 279 §483.25; and any services that would otherwise Residents #67, #13 and #73 care be required under §483.25 but are not provided plans have been reviewed and due to the resident's exercise of rights under updated to meet resident needs. \$483.10, including the right to refuse treatment Residents receiving dialysis, under §483.10(b)(4), oriented resident requiring assistance with transfers, and This REQUIREMENT is not met as evidenced resident with diagnosis of by: insomnia in facility have the Based on medical record review, observation, potential to be affected by the and interview, the facility falled to update the care alleged deficient practice. Care plan for one resident (#67) with concerns of not plans for resident with dialysis, getting out of bed; one resident (#13) for dialysis oriented with assistance needed access; and one resident (#73) for insomnia for a total of three of thirty residents reviewed. for transfers and those with diagnosis of insomnia will be The finding included: audited and updated. In-service/re-education to Resident #87 was readmitted to the facility on Interdisciplinary team which January 6, 2012, with diagnoses including includes DON, Unit managers, Chronic Atrial Fibrillation, Hypertension, Social services, Activities on Malnutrition, Diabetes Mellitus, Depression, developing, revising, updating Anxiety, Morbid Obesity, and Healing Stage IV care plans to meet individual Decubitl. needs of the resident was conducted by the regional Medical record review of the Quarterly Minimum Data Set (MDS) dated December 31, 2013, director of clinical. revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status exam Indicating the resident was cognitively intact. Continued review revealed the resident required extensive assistance from two persons for activities of cally

03/05/2014 13:21 8654940816 DEPOSIMENT OF TEALTH AND HUMAN SERVICES 8652125642 >> CENTERS FOR MEDICARE & MEDICAID SERVICES 8654948043 P 8/13 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE VOLIA IDENTIFICATION NURBER: FORM APPROVED (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-0: A BUILDING (X3) DATE SURVEY COMPLETED 445303 NAME OF PROVIDER OR SUPPLIER B. WING NORRIS HEALTH AND REHABILITATION CENTER 02/12/2014 STREET ADDRESS, ONY, STATE, ZIP CODE 3382 Andersonville Nighway ANDERSONVILLE, TN 97705 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMAY (ON) (X4) IO PREFIX TAG PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REPERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX TAG COMPLETION OATE F 279 Continued From page 6 During morning meeting IDT will living and personal hygiene, and was totally 4. F 279 dependent with assistance of two persons for review new orders and 24-hour report for last 24-72 hours and transfers. update care plans as needed. The Review of the Mental and Behavloral Health Visit QAPI committee will evaluate the Notes from the Licensed Clinical Social Worker effectiveness of the above plan (LCSW) dated November 25, 2013, January 7, for 3 months, and will add 2014, and January 21, 2014, revealed, "...want to additional interventions based on get up and out of ... rooom to distract ... and outcomes identified to ensure help...cope but says staff don't always follow through on getting...up...really needs to ge: out continued compliance. of ... room but staff can't seem to find the 03/14/14 time...feels discouraged and defeated..." Medical record review of the physician's recapitulation orders dated February 1 through February 28, 2014, revealed, "...Up in chair daily; out of bad daily as per pt (patient) request..." Medical record review of the care plan dated October 4, 2013, revealed the physician's order and the resident's request to get out of bed daily was not added to the care plan. Observation on February 11, 2014, at 10:30 a.m., and on February 12, 2014, et 10:00 a.m., in the resident's room, revealed the resident was in the bed. Observation and interview with the resident, in the resident's room, on February 11, 2014, at 10:30 a.m., confirmed the resident required assistance and use of a lift for transfers to get out of the bed. Continued interview confirmed the resident had not been able to get out of the bed as often as desired due to "not enough staff to get me up." Stated, "I am aware of the extra time and attention it takes to get me up because of my size

8654940816 NORRIS HEALTH&REHAB <014-02-25 13:50</p> PAGE DC0547PM13501 PERAKTMENT OF MEALTH AND HUMAN SERVICES 8652125642 >> CENTERS FOR MEDICARE & MEDICAID SERVICES 8654948043 P 9/13 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE/VCLIA IDENTIFICATION NUI/BER FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING NAME OF PROVIDER OR SUPPLIER 445303 B. WING STREET ACCRESS, CITY, STATE, ZIP CODE norris health and rehabilitation center <u>02/12/2</u>074 3382 andersonville Highway SUMMARY STATEMENT OF DISFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F. JLL REGULATORY OR LSC IDENTIFYING INFORMATION) ANDERSONVILLE, TN 37705 PROVIDERS PLAN OF GOHRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID PREPIX TAG TAG COMPLETION DATE F 279 | Continued From page 7 will get me up, but they never do." F 279 Interview on February 12, 2014, at 10:35 u.m., with the Minimum Data Set (MDS) Coordinator, in the MDS office, confirmed no knowledge of the LCSW's notes regarding the resident's concerns about not getting up, out of the bed. Continued interview confirmed the resident's care plan had not been revised to reflect the resident's preferences to be out of the bed delly.

Resident #13 was admitted to the facility on July 17, 2013, with diagnoses including End Stage Renal Disease, Hypertension, Hyperlipidemia, Depressive Disorder, Diabetes, and Ampulation Leg (bilateral).

Medical record review revealed the resident had a dialysis access (shunt) in the left upper arm and received dialysis three days a week at an out patient clinic,

Medical record review of the care plan dated January 30, 2014, revealed the care plan did not address the resident's dialysis access (shunt) located in the left arm or the standard of practice which requires no neadle sticks or blood pressure checks in the arm of the access,

Observation on February 11, 2014, at 3:15 p.m., nevealed the resident was in the resident's room watching TV.

interview with the Director of Nursing (DON on February 12, 2014, et 8:40 a.m., in the DON's office, confirmed the care plan did not address the resident's dialysis access in the left upper arm.

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014-02-25 1 DEPARTMEN CENTERS FO	i of Mealin Rimoada	DC0547PM135()1 AND HUMAN SERVICES & MEDICAID SERVICES	\$	8	3652125642 >>	86549480	43	
STATEMENT OF DEP	CENCIES	CAT DECAMES SERVICES	<u> </u>				FOR	MARROON
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Osteom	it #73 was ad ' 1, 2012, with Velitis, Mussia	b 8 mitted to the facility on diagnoses including Weaknese, Hyperionsion es, and Obstructive Sleep		279		(Y)		
Medical November revealed	gram) PO (by 'ecord review er 18, 2013, 5	in's order dated Novembe odone (antidepressent) 25 mouth) at 8:00 p.m of the care plan upcated nd February 6, 2014, dld not address the	#   					
Interview \$:55 p.m. resident v and was to Observation	with the DON at the main r vas receiving i nitiated on No	on February 11, 2014, at turses' station, verified the trazodone for insomnia, vember 7, 2013.						
revealed to watching ?		y 17, 2014, at 4:30 a.m., ss in the resident's room						
confirmed	the care plan nsomnia, ECTION COM	Coordinator on February of the MDS's office, did not address the NTROL, PREVENT	F 441					
safe, sanita to help pray of disease a	ry and comfor ant the developed and infection.	h and maintain an 1 dealgnad to provide a table environment and opment and transmission		a a	Preparation and/or execution of correction does not constitute add agreement by the provider of the alleged or conclusions set forth indeficiencies. The plan of correctiond/or executed solely because it moves ions of federal and state land	mission or truth of the fac In the statement on is prepared is required by i	ηŤ	
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AND PLAN	OF CORRECTION	(X1) PROVIDENSUPPLIETYCUA IDENTIFICATION NUMBER:	(XX) MULT A. BUTLON	IPLE CONSTRUCTION	(XS) D	O. 0938- TE SURVE
NAME OF	PROVIDER OR SUPPLIER	445303	B. WING			WS-LED
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(c) pies (c) has proper the base fallo	(1) Investigates, control in the facility; (2) Decides what processhould be applied to a scilons related to infect actions the infection interesting spread of the infect action in the spread of the resident.  2) The facility must proposed the facility must require the resident with transity. The facility must require facility must require facility must require facility must require facility must require facility must require facility must require facility must require facility must require facility must require facility must require facility must be facility must require facility must requ	blish an Infection Control it - it - iole, and prevents infections redures, such as isolation, in individual resident; and of incidents and corrective sitions, of infection Control Program lent needs isolation to infection, the facility must or infected skin teachs residents or their food, if not the disease, uire staff to wash their resident contect for which and by accepted  store, process and prevent the spread of not met as evidenced and interview, the facility		1. R #13 gown was immediated and new local cart was clean and new local cart was clean and new local cart was clean and new local cart was clean and new local cart was clear to prompt so led items and clothing, proprocedure for passing icc was local cart was local cart with managers and/or nursing observe icc pass and resident any soiled areas. The QAPI cart will evaluate the effectivenes plan for 3 months, and will act interventions based on outcom to ensure continued compliant.	w icc provided e potential to icnt practice s provided to nursing changing of oper ter. will be months by supervisor to solothing for committee s of the above ild additional mes identified	o ; ;
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NAME OF	PROVIDER OR SUPPLIER	A45303	B, WING_			- 11:41 - 14:41   11:41
VORRIS	HEALTH AND REHAB		1	STREET ADDRESS, CITY, STATE, ZIP CODE 3382 ANDERSONVALIE HIGHWAY ANDERSONVILLE, TN 37705		2/12/2 <b>01</b> 4
(X4) ID PREFIX TAG	(EACH DEFICIENCY) REGULATORY OR LE	EMENT OF DEFICIENCIES MUST BE PRECEDED BY F.A.L. C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO GROSS-REPERENCED TO THE APPL DEFICIENCY)	TION JULD BE ROPRIATE	COMPLET CATE
j	a a result of them bab		F 441	DEFICIENCY)		
In a state of the	dark spot on the reside observation revealed on the left side just ab regular in shape, me niches by two inches, everaled the spot appropriate of all yets access in the total yets access in the total yets access in the total yets access in the resident that gotter he dialysis treatment to 0, 2014). Continued it seldent returned to the help of the yets with the Direct 2014, at 12:59 p.m., onlined the solicit on	#13 on February 11 2014, sident's room, confirmed to blood on the gown from the day before (February interview confirmed the placifity between 5:00 p.m. the Activities room,				
Ottorion (C) hell glather obs	bruary 10, 2014.  Description on February the 100 hallway, reve NA) #5 retrieved a wa d the glass over the le ss with loe from the c glass to the resident; servation revealed Co	y 12, 2014, at 7:30 a.m., saled certified nurse aide ther glass from room: 113, be container, filled the ontainer, and returned a room. Continued				
Inte	rnig vic hallway. Tylew with CNA #5 on	fent in room 101 before  February 12, 2014, at a resident's water glass the ice container white		•	ļ	

NO PLAK	NT OF DEPICIENCIES OF CORRECTION	AND HUMAN SERVICES  E & MEDICAID SERVICES  (X1) PROVIDERSUPPLIES/CLIN	-	····	FORM	P 13/1
	, or sokued IDM	DENTIFICATION NUMBER	(X2) MULT A. BUTLON	(X3) DA	), 0938-0: C Sugary	
VALUE OF	PROVIDER OR SUPPLIER	445303	B. WING			APLETED.
MARRIE	The same and stabilities			STREET ADDRESS, CITY, STATE, ZIP CODE	02/	12/2014
	HEALTH AND REHAE	MLITATION CENTER		AND MADERSONVILLE HIGHWAY		
(X4) IQ PREFIX	SUMMARY STA	TEMENT OF DEPICIENCIES		ANDERSONVILLE, TN 37705		
TAG	REQULATORY OR LE	C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIENCY)		COSIPLETIC OATE
;	Water containers were	re 11 ice, rector of Nursing on February m., confirmed the resident's e not to be held over the ice the water containers.	F 441	(Drangesties and	or the facts lement of	<del></del>
463 8≃D	463,70(f) RESIDENT ROOMS/TOILET/BAT The nurses' station m esident cells through	0411 040	F 463	F463 Call lights in 3 rooms identified timmediately replaced		
fa or or Ot	ased on observation the celled to ensure the celled to ensure the celled for three of fifty-one finding included:  Description with medic February 12, 2014	al records staff member		Residents residing in facility have potential to be affected by this all deficient practice.  In servicing to staff to timely reported to mainter and administrator, DON, Maintenanc supervisor.  Call lights will be audited 3 times x 3 months by department bands.	eged ort any nance by e	
hui 14 fou two Inte	noted hallway reveal forms was not work in hundred hallway, represented to the market of the market with the market in the marke	at 10:00 a.m., in the one at 10:00 a.m., in the one call light in one of ng. Observation of the wealed the call lights in rooms were not working, all records staff member in confirmed the call lights.		x 3 months by department heads or rounds assigned by Administrator. QAPI committee will evaluate the effectiveness of the above plan for months, and will add additional interventions based on outcomes in the ensure continued compliance.  The maintenance team will perform weekly call light checks	n room The 3	